2009-2010 Regular Session
State Legislative Report

New Bills Since the Previous Board Meeting

AB 23 (Jones) Notification of COBRA and Cal-COBRA Premium Assistance
Version: Amended 03/19/2009
Sponsor: Author
Status: 03/23/2009-Assembly HEALTH. Set to be heard 03/24/09

This bill would state the intent of the Legislature to implement COBRA premium assistance made available by the federal American Recovery and Reinvestment Act (ARRA) of 2009. It would require employers, contracted administrators of Cal-COBRA and all health care plans and insurers to notify qualified beneficiaries that changes in federal law qualify employees involuntarily terminated between September 1, 2008, and December 31, 2009 for a 65% federal subsidy of Cal-COBRA premiums for up to nine months and that any eligible employee who had previously rejected Cal-COBRA has the right to withdraw that rejection and accept the coverage with the new subsidy.

AB 235 (Hayashi) Mandated Benefit: Emergency Psychiatric Services
Version: Introduced 02/06/2009
Sponsor: California Hospital Association
Status: 03/04/2009-Assembly HEALTH

This bill would add admission or transfer to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital to those emergency services that must be provided when necessary to relieve or eliminate a psychiatric emergency medical condition.

AB 1126 (Hernandez) Balance Billing CalPERS Members
Version: Introduced 02/27/2009
Sponsor: CalPERS
Status: 03/02/2009-First Reading

This bill would prohibit health care providers from balance billing CalPERS members for covered emergency services and care. The bill would allow providers to bill only the member's health benefit plan for emergency services and care.

AB 1144 (Price) Mandated Benefit: Prescribed Pain Medication
Version: Introduced 02/27/2009
Sponsor: For Grace
Status: 03/02/2009-First Reading

This bill would prohibit health care plans and insurers that cover prescription drug benefits from requiring, as a condition for authorizing coverage, that their subscribers or enrollees to use a prescription or over-the-counter pain product that differs from the medication the provider prescribed.

New Bills Since the Previous Board Meeting—continued

AB 1201 (V. Manuel Perez) Reimbursement for Childhood and Adolescent Immunizations
Version: Introduced 02/27/2009
Sponsor: California Medical Association
Status: 03/02/2009-First Reading

This bill would require all health care plans and insurers, and specifically HFP plans, to reimburse physicians and physician groups for childhood and adolescent immunizations at a rate no less than the actual cost of acquiring the vaccine plus the cost of administering it. The bill would include but not limit the vaccine acquisition cost to the invoiced purchase price plus reasonable costs associated with shipping, handling, insurance, and storage. Beginning January 1, 2010, the bill would require new immunizations not currently included in a contract or policy to be reimbursed at this rate. Also beginning January 1, 2010, the bill would prohibit health care plans and insurers that provide coverage for childhood and adolescent immunizations from imposing any cost-sharing mechanism for administering childhood or adolescent immunizations or for related procedures. It would further prohibit plan contracts and insurer policies from containing a reimbursement limit for childhood and adolescent immunizations.

AB 1218 (Jones) Plan/Insurer Rate Increase Approval
Version: Introduced 02/27/2009
Sponsor: Author
Status: 03/02/2009-First Reading

This bill would require health care plans and insurers to submit to the Department of Managed Health Care a request for approval of subscriber or enrollee rate increases, with exceptions. The bill would exclude state health programs, specifically the Healthy Families Program, from this requirement. The bill would also exclude rate increases of less than 5% of the plan's or insurer's minimum loss ratio (MLR) if the plan or insurer's reported MLR for the preceding three years is 90% or higher.

AB 1314 (Jones) DHCS Application for CMS Waivers
Version: Introduced 02/27/2009
Sponsor: Author
Status: 03/02/2009-First Reading

This bill would require the Department of Health Care Services (DHCS), no later than February 1, 2010, to: 1) apply to the federal Centers for Medicare and Medicaid Services (CMS) for a waiver to expand health care coverage for low- and moderate-income children and adults; 2) reduce the number of uninsured persons in the state; 3) maximize the acquisition of federal health care funds; 4) increase provider payments to ensure adequate access to primary and specialty health care for persons in state and local sponsored health care programs; 5) give quality and performance rewards to health care providers; 6) fund reimbursement mechanisms to support a health care safety net and delivery system; 7) improve fee-for-service health care delivery systems in state and local health care programs to better coordinate and manage health care services, emphasize timely primary and preventive care, and reduce the use and overuse of high-cost emergency and hospital inpatient services; and 8) improve coordination and efficiency of state and local health care programs and mental health care programs.

New Bills Since the Previous Board Meeting—continued

AB 1503 (Lieu) Provider Reimbursement for Unpaid Emergency Health Care Services
Version: Introduced 02/27/2009
Sponsor: Health Access, Western Center on Law and Poverty
Status: 03/02/2009-First Reading

This bill would repeal certain current criteria for providers requesting reimbursement from the state for nonpayment of emergency services and care. The bill would require providers to either provide a discount or to bill the Maddy Emergency Medical Services Fund (Maddy Fund), a state-established county-administered fund from which any physician and surgeon may be reimbursed for up to 50% of the amount claimed. If the provider determines the patient is eligible for the discount, the bill would permit patients with incomes at or below 350% of the federal poverty level (FPL) to apply to the provider for the provider's discount. The bill would require the provider's discount to limit their expected payment to either the greater of the Medi-Cal, Healthy Families Program or other state health program rate in which the provider participates or to another appropriate discount rate. If the provider wishes to bill the Maddy Fund, the bill would require the provider to first determine whether the patient qualifies for the hospital's charity care. If the patient does qualify, and the provider bills the Maddy Fund, the provider would be required to cease billing or collecting from the patient. It would require providers to make all reasonable efforts to determine whether private or public health insurance, including HFP, may fully or partially cover the providers charges for emergency services. With exceptions, the bill would prohibit garnishing the wages of patients receiving the providers discount or selling their primary residence.

AB 1541 (Assembly Health) Healthy Families Implementation of Federal Stimulus
Version: Introduced 03/04/2009
Sponsor: Author
Status: 03/05/2009-First Reading

This bill would declare the intent of the Legislature to enact legislation that would implement, among other federal measures, the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the federal economic stimulus package.

SB 600 (Padilla) New Cigarette Tax
Version: Introduced 02/27/2009
Sponsor: American Cancer Society
Status: 03/19/2009-Senate HEALTH

This bill would create the Tobacco Tax and Health Protection Fund. It would, in addition to existing cigarette taxes, impose an additional tax upon every distributor of cigarettes at the rate of $0.0075 for each cigarette distributed on or after the first calendar quarter commencing more than 90 days after the bill's enactment and would deposit the new taxes into this fund. The bill would require that funds then be transferred from the Tobacco Tax and Health Protection Fund to the California Children and Families First Trust Fund, the Hospital Services Account, the Physician Services Account, the Unallocated Account of the Cigarette and Tobacco Products Surtax Fund, and the Breast Cancer Fund, as needed to offset the revenue decrease directly resulting from imposition of the bill's new taxes. The bill would allow these funds to only supplement existing levels of service and not to fund existing levels of service.

SB 630 (Steinberg) Mandated Benefit: Orthodontic Reconstructive Surgery
Version: Introduced 02/27/2009
Sponsor: Author
Status: *03/19/2009-Senate HEALTH. Set for hearing April 15.*

This bill would prohibit health care plan contracts and insurance policies from excluding coverage for dental or orthodontic services medically necessary to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to create a normal appearance.

SB 727 (Cox) Mandated Continuation Coverage, Cal-COBRA
Version: Introduced 02/27/2009
Sponsor: Author
Status: 03/19/2009-Senate HEALTH

This bill would require health care plans and insurers to offer continuation coverage to subscribers and enrollees covered by an employer group benefit plan that the employer terminates without providing a successor group benefit plan to its employees. The bill would require this coverage to extend for not less than 18 months from the termination date and under the same terms and conditions as the terminated coverage.

SB 796 (Alquist) COBRA and Cal-COBRA
Version: Introduced 02/27/2009
Sponros: Author
Status: 03/19/2009-Senate HEALTH

This bill would repeal the current requirement that a person must elect and exhaust COBRA or Cal-COBRA coverage in order to qualify for access to individual health care coverage without preexisting condition exclusions as a federally eligible defined individual under the federal Health Insurance Portability and Accountability Act (HIPAA).

SB 810 (Leno) Universal Health Care
Version: Introduced 02/27/2009
Sponsor: One Care Now, Health Care For All
Status: *03/19/2009-Senate HEALTH. Set for hearing April 15.*

This bill would state the intent of the legislature to establish a single system of universal health care coverage and a single public payer for all health care services in California. To that end, this bill would create the California Healthcare Agency, an independent agency under the control of a Healthcare Commissioner appointed by the governor on or before March 1, 2010 and confirmed by the Senate. The bill would require the system to become operational no later than two years from the date the Secretary of the California Health and Human Services agency determines that the Healthcare Fund, created for this bill's purposes, will have sufficient revenues to fund the costs of implementing the bill. The California Healthcare Agency would supervise the California Healthcare System Plan. The bill would further prohibit any health care service plan contract or health insurance policy, except for the California Healthcare System Plan, from being sold in California for services provided by the system. The bill would require the Managed Risk Medical Insurance Board (MRMIB) to serve, with other departments and agencies, on an

advisory panel that would make recommendations to the commissioner on how to establish the system throughout local regions. All people physically present in the state with the intent to reside in it would be eligible for the California Healthcare System Plan.

Bills Amended Or With Changed Status Since The Last Board Meeting
Note: deleted content appears ~~stricken~~, and new bill content or status is *italic.*

AB 259 (Skinner) Mandated Benefit: OB/GYN Services From a Certified Nurse-Midwife
Version: Introduced 02/11/2009
Sponsored: Author
Status: 03/09/2009-Assembly HEALTH

This bill would require health care plans and insurers to allow their enrollees to obtain obstetrical and gynecological (OB/GYN) services directly from a certified nurse-midwife without prior approval from another physician, another provider, or the health care service plan.

AB 513 (De Leon) Mandated Benefit: Consultation and Equipment Related To Breast-Feeding
Version: Introduced 02/24/2009
Sponsor: WIC Association
Status: *03/12/2009-Assembly HEALTH*

This bill would require health care insurance contracts and policies that cover maternity care to also cover specified consultation and equipment rental related to breast-feeding.

AB 542 (Feuer) Adverse Medical Events
Version: Introduced 02/25/2009
Sponsor: Author
Status: *03/12/2009-Assembly HEALTH*

This bill would require the Director of the Department of Public Health (DPH) to establish the Office of Quality Improvement and Reporting, which would provide state leadership in reducing adverse events and improve patient safety and quality of care. The bill would require the California Health and Human Services Agency (CHHS) to establish the Health Care Quality Improvement Committee (HCQIC) for the purpose of developing recommendations for nonbilling and nonpayment policies and practices for adverse events substantiated by the Department of Health Care Services (DHCS). The bill would also require one representative from MRMIB to serve as an ex-officio member of the HCQIC among representatives from several other health care-related state entities. The bill would require the HCQIC to meet bi-monthly and recommend to CHHS the following: 1) policies and practices for determining the care or services related to the adverse event that should not be billed or paid; 2) methodologies to monitor and enforce compliance; 3) appeal processes; 4) guidelines for health care providers and payers regarding adverse events; and 5) methodologies to synchronize definitions, coding, and practices with CMS related to adverse events. It would require the HCQIC to make initial recommendations by September 1, 2010, and to make full recommendations within 12 months of its initial recommendations or no later than October 1, 2011.

This bill would add new events to the statutory list of adverse events that providers are required to report. The bill would require health facilities or surgical clinics to inform affected patients of the adverse event. The bill would require DHCS to report adverse events to state government payers of claims for health care services, including MRMIB, and would require MRMIB and these other state payers to maintain the confidentiality of this information. It would require the state payers that receive this information, such as MRMIB, to share the costs of collecting it in proportion to the ratio of the information each agency receives.

This bill would require health care contracts between providers and plans or insurers to be consistent with nonpayment and nonbilling policies and practices for adverse events, as defined by CMS and the HCQIC, that are substantiated by DHCS. The bill would prohibit health care providers from billing patients for adverse events.

This bill would require DHCS, DPH and MRMIB to share reasonable costs of the HCQIC and provide administrative and staffing support contingent upon legislative appropriation for the support. It would also require DHCS, DPH and MRMIB to seek federal financial participation to support HCQIC activities. It would also allow DPH to partner with an independent nonprofit group, foundation or academic institution or governmental entity to assist with HCQIC activities. Further, it would allow CHHS to accept and expend private funds for the purposes of the HCQIC. The bill would require state and local health care programs receiving federal funds to comply with the measure only insofar as their federal financial participation is not jeopardized. The HCQIC and the provisions related to it would sunset on July 1, 2013, unless extended by statute.

This bill would require MRMIB and the DHCS to implement adverse event nonbilling and nonpayment policies and practices consistent with the HCQIC's recommendations accepted by the CHHS but only if and to the extent that federal financial participation is available and is not jeopardized. The bill would allow MRMIB to contract with a state and federally compliant review organization to assist in carrying out the HCQIC recommendations. The bill would prohibit providers from billing Medi-Cal patients for care and services for which payment is denied by the Medi-Cal program or any other program administered by the DHCS related to this bill.

AB 783 (Anderson) State Government: Agencies, Commissions, Boards: Repeal.
Introduced: 02/26/2009
Sponsor: Author
Status: 3/23/2009-Assembly BUSINESS & PROFESSIONS

This bill would abolish, on January 1, 2022, all statutorily created state agencies, boards, and state commissions that are funded by General Fund revenues, except for the Franchise Tax Board.

AB 786 (Jones) Individual Health Care Coverage: Coverage Choice Categories.
Version: Introduced 02/26/2009
Sponsor: Health Access
Status: 3/23/2009-Assembly HEALTH

This bill would require, by September 1, 2010, the Department of Managed Health Care (DMHC) and the Department of Insurance (CDI) to jointly develop a system to categorize all health care service plan contracts and health insurance policies offered and sold to individuals into five coverage choice categories. The bill would require individual health care contracts and policies offered or sold on or after January 1, 2011, to contain a maximum dollar limit on out-of-pocket costs for covered benefits. The bill would authorize health care plans and insurers to offer contracts and policies in any coverage choice category, subject to restrictions. The bill would also require health care plans and insurers to establish prices for individual contracts and policies

that reflect a reasonable continuum between the coverage choice categories with the lowest level of benefits and the highest level of benefits.

SB 92 (Aanestad) Health Care Reform
Version: Amended 02/25/2009
Sponsor: Author
Status: *03/11/2009-Senate HEALTH*

The bill would authorize health care plans and insurers to sell individual contracts and policies that do not include all of the benefits mandated under state law to individuals with income below 350% of the federal poverty level if the individual waives those benefits and the contract or policy is approved by the Department of Managed Health Care (DMHC) or the California Department of Insurance. This bill would further allow an out-of-state health care plan or insurer to offer, sell, or renew a health care contract or policy in this state without holding a license or a certificate of authority issued by the DMHC.

This bill would permit only a health care professional licensed in California to deny, delay, or modify requests for authorization of health care services and only for services that fall within his or her scope of practice. The bill would also require this authorizing licensee to have at least the same scope of practice as the provider who requests authorization. The bill would also require this licensee to first conduct a good-faith examination of the enrollee or insured before denying, delaying, or modifying the request.

The bill would also require the DMHC, on or before January 1, 2011, to provide or arrange for the provision of an electronic personal health record and an electronic personal benefits record for beneficiaries of the Medi-Cal program. The bill would additionally authorize the DMHC to establish a Healthy Action Incentives and Rewards Program as a covered benefit under the Medi-Cal program, subject to federal financial participation and approval.

The bill would state the intent of the Legislature to enact legislation that would realign Medi-Cal benefits to more closely resemble benefits offered through private health care coverage.

This bill would permit a hospital or health care provider that provides health care services to an uninsured individual who does not qualify for government health care benefits to file a claim with the State Department of Health Care Services to be reimbursed for those services if the recipient of the services does not pay for those services. The bill would allow the medical debt owed by the uninsured individual to be paid with any tax refund or lottery winnings owed by the state to the individual.

This bill would require the CalPERS Board to offer a high deductible health plan and a Health Savings Account option to public employees and annuitants. The bill would establish the Public Employees' Health Savings Fund for payment of qualified medical expenses of eligible employees and annuitants who elect to enroll in the high deductible health plan and participate in the Health Savings Account option and would require those employees and annuitants and their employers to make specified contributions to that fund. The bill would also require the CalPERS Board, on or before January 1, 2011, to provide for an electronic personal health record and an electronic personal benefits record for enrollees receiving health care benefits and to provide a Healthy Action Incentives and Rewards Program to its enrollees.

This bill would require corporations licensed to receive money for the purpose of transmitting it to foreign countries to charge a fee to customers unable to provide documentation of lawful presence in the United States to be used to pay for emergency medical treatment for undocumented residents.

SB 158 (Wiggins) Mandated Benefit: Human Papillomavirus Vaccination
Version: Introduced 02/12/2009
Sponsor: Author
Status: *3/9/2009-Senate HEALTH*

This bill is similar to bills AB 16 and AB 1429, both vetoed, from the 2007-08 regular session. This bill would require that individual and group health care plan contracts and health care insurer policies that are amended or renewed on or after January 1, 2010, and that include coverage for treatment or surgery of cervical cancer, must also provide coverage for the human papillomavirus vaccination.

SB 161 (Wright) Mandated benefit: Parity Coverage for Orally-Administered Cancer Medications
Version: Introduced 02/14/2009
Sponsor: Kerry's Touch African-America Breast Cancer Association
Status: 3/9/2009-Senate HEALTH

This bill would require that health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2010, and that cover cancer chemotherapy treatment, must also provide coverage for cancer medications administered orally, and specifies that such coverage must be on an equal basis with coverage provided for cancer medications administered intravenously or injected.

SB 227 (Alquist) MRMIP Expansion
Version: Introduced 02/23/2009
Sponsor: Author
Status: 3/9/2009-Senate HEALTH

This bill would require health care plans and insurers to accept individuals eligible for the Major Risk Medical Insurance Program (MRMIP) regardless of health status or previous health care claims experience. It would require plans to provide guaranteed-renewable coverage to persons assigned by MRMIB with the same level of benefits as the MRMIP, as determined by MRMIB, and to charge those persons premium rates determined by MRMIB. It would permit plans to avoid covering these individuals by instead paying a fee determined by MRMIB . The fees would be paid to the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI) and transmitted to MRMIB within 30 days of receipt. The bill would allow MRMIB to obtain loans from the General Fund for all necessary and reasonable expenses, to be repaid with interest no later than January 1, 2017. The bill would require MRMIB to establish a process for individuals in the Guaranteed Issue Pilot program to voluntarily re-enroll into the MRMIP. This re-enrollment would be conditioned on the absence of a MRMIP waitlist. The bill would allow plans and insurers without preexisting condition provisions in their contracts to impose a waiting or affiliation period, not to exceed 90 days, before the coverage issued becomes effective.

The bill would require MRMIB to establish the scope of coverage for the program and minimum standards for plan participation. It would require that benefits in the program provide comprehensive coverage, including, effective January 1, 2011, lower subscriber cost sharing for primary and preventive health care services and the medications necessary and appropriate for the treatment and management of chronic health conditions. It would require benefits, subscriber cost sharing, and out-of-pocket costs to be appropriate for a program serving high-risk and medically uninsurable persons. It would require MRMIB, to the greatest extent possible, to establish benefits that are compatible with comprehensive coverage products available in the individual health insurance market, but not less than the minimum benefits required under the Knox-Keene Act. It would permit MRMIB to offer more than one benefit design option with different subscriber cost sharing in the form of copayments, deductibles, and annual out-of-pocket costs. The bill would require coverage in the program to have no annual benefit limit and no lifetime limit of less than $1,000,000. It would change current law to permit rather than require MRMIB to prescribe a period of ineligibility before applying for the program if the individual was previously terminated for nonpayment of premium. It would also permit this, with MRMIB discretion, if the individual voluntarily disenrolled from a participating health plan.

The bill would require MRMIB to establish subscriber contributions at no more than 200% of the standard average individual rate for comparable coverage. For subscribers at or below 300% of the federal poverty level the bill would require a sliding scale with lower contribution requirements, but in no case would subscriber contribution be permitted lower than 110% of the standard average individual rate for comparable individual coverage, unless federal funds are received. Upon receipt of federal funds, it would require MRMIB to lower subscriber contributions for subscribers at or below 300% of the federal poverty level to 6% of income, and would also permit lower subscriber contributions for subscribers over 300% but less than 500% of the federal poverty level with any remaining federal funds.

Commencing February 1, 2010 and annually thereafter, the bill would require health plans and insurers to notify MRMIB whether they will cover individuals assigned to them or alternatively pay a fee as determined by MRMIB. It would further require plans and insurers to report to MRMIB the total number of covered lives and their medical loss ratio (MLR) by May 1 of each year. MRMIB would be required to determine the amount of the fee, which would be limited to no more than $1 per member per month for those plans and insurers at the bottom MLR quartile. Commencing January 1, 2010 and at least annually thereafter, the bill would require the Guaranteed Issue Program (GIP) plans and insurers to report the number of covered lives remaining in continuation coverage and other information MRMIB requires to implement GIP.

The bill would require MRMIB to appoint an 11-member panel that would be ready to advise MRMIB on this program by February 1, 2010. It would require the advisory panel to make recommendations to:

1. Improve the quality of health care provided to subscribers in the program.
2. Advise MRMIB on policies and program operations.
3. Make recommendations to ensure the affordability of coverage for subscribers, especially low-income subscribers.
4. Make recommendations to ensure the cost-effectiveness of health care provided to subscribers in the program.
5. Meet at least quarterly, unless deemed unnecessary by the chair.

It would require MRMIB to respond to the panel in writing when MRMIB rejects any of the panel's written recommendations. By September 1, 2010 it would require MRMIB to make recommendations to the Legislature based on the panel's recommendations regarding the status of benefits and premiums provided to federally eligible defined individuals. It would further require MRMIB to obtain an actuarial analysis and comparison between benefits and premiums in the program and those in the individual market for federally eligible defined individuals, to recommend needed policy changes and to discuss the impact of any changes in the program on premium rates and coverage for federally eligible defined individuals.

It would require MRMIB, on or before July 1, 2012, to report to the Legislature on the implementation of the bill, including an implementation and transition plan for an alternative approach to ensuring quality coverage for high risk, potentially high cost individuals, other than a segregated high risk pool, that may include a reinsurance mechanism or a risk adjustment mechanism, or both. The transition plan would be required to outline the steps MRMIB would need to take in order to replace the program with an alternative mechanism by January 1, 2014.

The bill would augument current appropriations from the Cigarette and Tobacco Products Surtax Fund (Proposition 99) by approximately $6 million. The bill would require MRMIB to use accumulated fees that exceed operation costs for this program to reduce fees in the following year.

The bill would require MRMIB to use accumulated fees that exceed operation costs for this program to reduce fees in the following year.

The bill would provide authority for emergency regulations to implement this measure.

SB 270 (Alquist) Health Information Technology
Version: Introduced 02/24/2009
Sponsor: Author
Status: 3/9/2009-Senate HEALTH

This bill, on and after January 1, 2011, would require a state agency that contracts with a health care provider, plan or health insurer to include in the contract a provision requiring the provider, plan, or insurer, to utilize systems and products that meet federal standards when implementing, acquiring, or upgrading its health information technology systems.

SB 316 (Alquist) Minimum Loss Ratio
Version: Introduced 02/25/2009
Sponsor: Author
Status: 3/9/2009-Senate HEALTH

This bill would require full service health care service plans and health insurers to expend on benefits no less than 85% of the aggregate dues, fees, premiums, and other periodic payments they receive with respect to contracts or policies issued, amended, or renewed on or after January 1, 2011. The bill would authorize these plans and insurers to assess compliance with this requirement by averaging their total costs across all plan contracts or insurance policies issued, amended, or renewed by them and their affiliated plans and insurers in California, except as specified. The bill would require these plans and insurers to annually, commencing January 1,

2011, provide written affirmation of compliance with the bill's requirements to the Department of Managed Health Care (DMHC) or the Department of Insurance (CDI), and would also require these plans and insurers to annually, commencing January 1, 2011, report to the DMHC or CDI the medical loss ratio of each individual and small group plan product and policy form issued, amended, or renewed in California. It would also require plans and insurers to report the ratio when presenting a plan for examination or sale to any individual or group consisting of 50 or fewer individuals.

SB 438 (Yee) Cal-Health Act
Version: Introduced 02/26/2009
Sponsor: California Nurses Association
Status: *03/12/2009-Senate HEALTH. Set for hearing April 15.*

This bill would require MRMIB, in consultation with the Department of Health Care Services (DHCS), to begin, on or before July 1, 2010, the transfer of initial and ongoing eligibility determinations for the Healthy Families Program (HFP) to county welfare departments. The bill would also create the Cal-Health Program, which would provide coordination of the Healthy Families and Medi-Cal programs by the Secretary of California Health and Human Services, with the assistance of MRMIB, the DHCS, and county welfare departments. The bill would authorize participating providers, to the extent permitted under federal law, to screen and temporarily enroll a child in the Medi-Cal program or the HFP at the time medical care is provided, and would require reimbursement of the provider to the same extent as if the child were fully enrolled in the program in which he or she is temporarily enrolled. This bill would require the DHCS, to the extent federal financial participation is available, to exercise the option to simplify Medi-Cal eligibility by exempting all resources from consideration in making eligibility determinations and to adopt an income disregard for applicants equal to the difference between that income standard and the amount equal to 133% of the federal poverty level applicable to the size of the family. The bill would also require the DHCS, subject to approval of any necessary state plan amendments, to implement a program for accelerated enrollment of pregnant women in the Medi-Cal program and would make each county welfare department a qualified entity for determining eligibility for Medi-Cal benefits for children and pregnant women.

SB 499 (Ducheny) MRMIB Reporting of the Use of DMHC Fines Transferred to MRMIP
Version: Introduced 02/26/2009
Sponsor: Author
Status: *03/12/2009-Senate HEALTH. Set for hearing April 1.*

This bill would require MRMIB to report to the Legislature no later than March 1, 2010, and annually thereafter, on the amount and use of moneys transferred to the Major Risk Medical Insurance Fund and the effect of those moneys on the waiting list for the Major Risk Medical Insurance Program.

Bills That Remained Unchanged Since The Previous Board Meeting

AB 2 (De La Torre) Rescission
Version: Introduced 12/01/2008
Sponsor: California Medical Association
Status: 02/05/2009-Assembly HEALTH

This bill is substantively the same as AB 1945 of the 2007-08 session. The bill would require health plans and insurers to obtain prior approval from the Department of Managed Health Care (DMHC) Director and the California Department of Insurance (CDI) Commissioner respectively before rescinding any health coverage. It would require the DMHC Director and CDI Commissioner, beginning January 1, 2011, to jointly establish an independent process for reviewing health plans' and insurers' requests to rescind an enrollee's coverage. It would allow DMHC or CDI to approve a rescission only if the health plan or insurer demonstrated that the enrollee "made a material misrepresentation or material omission" about his or her medical history in the application process. The bill would also permit each regulator to assess other administrative penalties and suspend or revoke a plan's license or insurer's business certificate if they rescind coverage without prior DMHC or CDI approval. It would also require DMHC and CDI to establish by regulation an exclusive pool of approved questions for use on individual coverage applications by health plans and insurers that elect to sell individual coverage, and would require the plans and insurers to use these questions no later than six months following passage of the regulation. The bill would require that on and after January 1, 2011 all individual health care applications be reviewed and approved by DMHC and CDI prior to being used by plans and insurers.

AB 29 (Price) Dependent Age Limit Minimum
Version: Introduced 12/01/2008
Sponsor: Author
Status: 02/05/2009-Assembly HEALTH

This bill, effective January 1, 2010, would prohibit those plans and insurers that terminate coverage for dependent children when they reach a specified age from setting that limit at less than 27 years of age. It would exempt collective bargaining contracts effective prior to January 1, 2010. The bill would further stipulate that employers such as CalPERS that participate in the Public Employees' Medical and Hospital Care Act would not be required to pay the cost of coverage for dependents between 23 and 27 years of age.

AB 56 (Portantino) Mandated Benefit: Mammography Screening
Version: Introduced 12/05/2008
Sponsor: Author
Status: 02/05/2009-Assembly HEALTH

This bill would require individual and group health care insurance policies to cover mammography screening and diagnosis beginning July 1, 2010. It would further require that health plans and disability insurers give written notice to their respective female enrollees and policyholders of their eligibility for breast cancer testing using nationally recommended testing guidelines for women.

Bills That Remained Unchanged Since The Previous Board Meeting—continued

AB 89 (Torlakson) Cigarette Tax for Children's Health Care
Version: Introduced 01/05/2009
Sponsor: Author
Status: 02/23/2009-Assembly REVENUE & TAXATION

This bill would, shortly following its passage, impose a new tax of 10.5 cents on each cigarette and a new tax ranging from $1.05 to $2.625 for each pack of cigarettes in addition to current tobacco taxes. The bill would create the Tobacco Excise Tax Account and deposit the tax into the Account, which would be used for general and children's health care, education, tobacco cessation services, and lung cancer research. This bill would take effect immediately.

AB 98 (De La Torre) Mandated Benefit: Insurer Maternity Coverage
Version: Introduced 01/06/2009
Sponsor: Author
Status: 02/23/2009-Assembly HEALTH

This bill would require that individual or group health insurance policies issued, amended, renewed, or delivered on or after January 1, 2010, must cover maternity services.

AB 108 (Hayashi) Individual Health Care Coverage Rescission
Version: Amended 02/26/2009
Sponsor: Author
Status: 02/26/2009-Assembly HEALTH

This bill would prohibit a health care plan and insurer from rescinding an individual contract or policy for any reason after 18 months following the issuance of the contract or policy.

AB 163 (Emmerson) Mandated Benefit: Amino Acid-Based Elemental Formulas
Version: Introduced 01/27/2009
Sponsor: American Partnership for Eusinophilic Disorders
Status: 02/26/2009-Assembly HEALTH

This bill would require health care insurance policies and non-specialized plan contracts that are amended or renewed on or after January 1, 2010, and that provide coverage for hospital, medical, or surgical expenses, to provide coverage for the use of amino acid-based elemental formulas, regardless of the delivery method, for the diagnosis and treatment of eosinophilic gastrointestinal disorders when the prescribing physician has issued a written order stating that the amino acid-based elemental formula is medically necessary. Eosinophilic disorders are characterized by having elevated levels of a certain type of white blood cell in the digestive system.

AB 214 (Chesbro) Mandated Benefit: Durable Medical Equipment
Version: Introduced 02/03/2009
Sponsored: Debra and Doctor Coalition
Status: 02/03/2009-First Reading

This bill would require health plan contracts and health insurance policies issued, amended, received, or delivered on or after January 1, 2010 to cover Durable Medical Equipment (DME)

and services. DME is equipment designed for repeated use and that is used for treating a patient and/or for preserving the patient's functioning.

AB 244 (Beall) Mandated Benefit: Mental Health Services
Version: Introduced 02/10/2009
Sponsor: Author
Status: 02/10/2009-First Reading

This bill would require health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2010, to include the diagnosis and treatment of a mental illness of a person of any age and would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual IV (DSM IV). The bill would exclude Medi-Cal plans and insurers. It would also exclude CalPERS plans and insurers unless CalPERS purchases a plan, contract, or policy that provides mental health coverage.

AB 689 (Calderon, Charles) Cigarette and Tobacco Products Tax Law: Tobacco Products
Version: Introduced 02/26/2009
Sponsor: California Distributors
Status: 02/26/2009-First Reading

This bill would revise the definition of tobacco products relative to the Tobacco Tax and Health Protection Act of 1988 (Proposition 99). Where current law differentiates "cigarettes" from "tobacco products," the bill would redefine tobacco products as any articles or products that are made of or contain any level of tobacco. Current law limits such articles or products to only those that contain at least 50 percent tobacco. A change to the Tobacco Tax and Health Protection Act of 1988 requires a four-fifths vote of both legislative houses and is then allowed only if the change is consistent with the act.

AB 722 (Lowenthal, Bonnie) Mental Health Pre-existing Conditions.
Version: Introduced 02/26/2009
Sponsor: Mental Health Association
Status: 02/26/2009-First Reading

This bill would state the intent of the Legislature to enact legislation to provide that a person with a history of seeking mental health treatment or of having a prescription for mental health medication shall not be determined to have a pre-existing condition or otherwise be denied coverage by a health care service plan or a health insurer. This provision is conditioned on the absence of comprehensive health care reform that guarantees group coverage to all.

AB 730 (De La Torre) Penalties for Unlawful Rescission of Policies
Version: Introduced 02/26/2009
Sponsor: Insurance Commissioner
Status: 02/26/2009-First Reading

This bill would allow the Insurance Commissioner to penalize health insurers who unlawfully rescind health insurance policies in an amount up to $5,000 for each unlawful rescission. It would further authorize the Commissioner to increase the penalty, if the insurer knew or had reason to know that the act of rescission was unlawful, to up to $10,000 for each act or violation.

Bills That Remained Unchanged Since The Previous Board Meeting—continued

ACA 1 (Silva) Legislative Vote Requirement For Expenditures
Version: Introduced 12/01/2008
Sponsor: Author
Status: 12/01/2008-First Reading

This bill would require the Department of Finance to analyze all bills introduced or amended and to report to specified legislative entities whether the bill would result in more than $150,000 in annual expenditures. ACA 1 would require that such bills may pass from the legislature only upon a 2/3 approval vote of each house.

ACA 4 (Bass) Vote Requirements For Budget Bills
Version: Introduced 12/03/2008
Sponsor: Author
Status: 12/08/2008-First Reading

This bill would exempt budget bills and budget implementation bills (trailer bills) from being subject to the referendum process. It would also require these bills to go into effect immediately upon being signed by the governor. It would define budget and trailer bills in such a way as to limit them to budget issues. It would further exempt budget and trailer bills passed on or before June 15 from the requirement that they receive a 2/3 approval vote in the legislature thereby allowing them to be passed with a majority vote only.

SB 1 (Steinberg) Statewide Children's Health Care Coverage
Version: Amended 2/12/2009
Sponsor: 100% Campaign
Status: 02/12/2009-Senate HEALTH

This bill is similar to AB 1 and SB 32 of the 2007-08 session. By January 1, 2010 and insofar as state funds are appropriated for its purposes, this bill would expand the income eligibility level for the Healthy Families Program (HFP) to 300% of the Federal Poverty Level (FPL) and would repeal immigration status as an eligibility criterion for Medi-Cal and the HFP. The bill also states its intent that the Managed Risk Medical Insurance Board (MRMIB) may implement the expansion only to the extent that funds are appropriated for that purpose. The premium rate for the 250% to 300% FPL population would be 150% of the premium rate enrollees pay in the 200%-250% FPL category.

The bill would also, by July 1, 2011, establish the Healthy Families Buy-In Program and would allow children uninsured for the previous six months and in families with income greater than 300% of the FPL to purchase enrollment in the HFP and obtain coverage identical to the HFP coverage. The bill would deem Buy-In enrollees eligible for the California Children's Services (CCS) Program and would require that these enrollees pay MRMIB the full cost of the HFP health, vision and dental coverage plus the per capita actuarial value of the CCS services. The bill would further require the state to reimburse counties for the cost of meeting administrative standards for that portion of the county caseload that provides services to Buy-In children.

By July 1, 2011, the bill would allow families to self-certify their income when initially applying for HFP, and it would require MRMIB and stakeholders to simplify the annual renewal forms, such as providing the forms pre-populated with the enrollee's eligibility information and a

check-list identifying whether eligibility information items are correct. It would also require MRMIB and stakeholders to establish a process of renewal by phone.

The bill would expand Medi-Cal eligibility for children ages 6 through 18 from 100% of FPL to 133% of FPL by January 1, 2010. Upon implementation of this expansion, the bill would require MRMIB and the Department of Health Care Services (DHCS) to develop a process to transition eligible children from local Children's Health Initiative (CHI) programs to Medi-Cal and the HFP. The bill also, to the extent federal financial participation is available, would establish the Medi-Cal Presumptive Eligibility Program by July 1, 2011 for new Medi-Cal/HFP applicants.

SB 56 (Alquist) Universal Access to Health Care Coverage
Version: Introduced 01/20/2009
Sponsor: Author
Status: 01/29/2009-Senate RULES

This bill states the intent of the Legislature to, by 2012, enact health care reform that would ensure all Californians have access to affordable, quality health care coverage. It also states legislative intent to equitably distribute the responsibility for providing and paying for health care coverage between individuals, employers and government, and to further reduce the reliance on medical status or conditions as criteria for medical underwriting of individual coverage. The bill also states the intent of the Legislature, by 2010, to provide a foundation for future reforms, such as ensuring coverage for all children, allowing workers to set aside pre-tax health care dollars, beginning to draw down federal funds for covering low-income adults and families, and reducing the use of medical underwriting.

SB 57 (Aanestad) MRMIP Changes
Version: Introduced 01/20/2009
Sponsor: Author
Status: 01/29/2009-Senate HEALTH

This bill would require the Managed Risk Medical Board (MRMIB) to offer at least four different coverage options in the Major Risk Medical Insurance Program (MRMIP), including at least one option compatible with a health savings account. These options would be required to include deductibles from $500-$2,500 for individuals and $1,000-$4,000 per family as well as out-of-pocket maximums from $2,500-$5,000 per individual and $4,000-$7,500 per family. The bill would limit the annual benefits coverage for each subscriber to $150,000 but would allow MRMIB to lift this cap by January 1, 2015, if sufficient funds permit it. It would impose a lifetime maximum benefit limit of $1 million until January 1, 2015. The bill would allow MRMIB, pending sufficient funding, to buy deductible and out-of-pocket maximum reinsurance until January 1, 2015. This bill would increase from one to three the number of plans that must reject applicants before they qualify as having a medically uninsurable condition. It would require that the condition be documented by a physician and that MRMIB determine those conditions that would qualify as medically uninsurable for this purpose. It would define resident, for purposes of eligibility, as someone who has either resided in California for six months prior to applying for MRMIP or is present in California and provides documentation of recent participation in a high-risk health insurance program in another state.

The bill would allow MRMIB, until January 1, 2015, to create a "rider" pool of applicants who have no more than two qualifying medical conditions, as determined by MRMIB. It would prohibit these qualifying conditions from including conditions likely to require chronic, ongoing care. The bill would allow individual health care plans and insurers to exclude these qualifying conditions from coverage temporarily or permanently for these "rider" members.

This bill, after June 30, 2010, would increase the appropriation from the Cigarette and Tobacco Products Surtax Fund (Proposition 99) to the Major Risk Medical Insurance Fund by $10 million (from $18 million to $23 million from the Hospital Services Account and from $11 million to $16 million from the Physician Services Account). This bill would further require health care plans and insurers that provide individual coverage for hospital, medical, or surgical benefits to add a surcharge to each life covered according to the following schedule:

1. July 1, 2010, through June 30, 2011, a surcharge of $0.35 per life, per month.
2. July 1, 2011, through June 30, 2012, the surcharge of $0.50 per life, per month.
3. July 1, 2012, through June 30, 2013, the surcharge of $0.70 per life, per month.
4. July 1, 2013, through June 30, 2014, the surcharge of $0.85 per life, per month.
5. July 1, 2014, and thereafter, the surcharge of $1 per life, per month.

The bill, until January 1, 2015, would require these surcharges to be deposited into the Major Risk Medical Insurance Fund and would allow the surcharges to be paid in two installments on August 1 and December 15 of each year. If state funds in the Major Risk Medical Insurance Fund are less than $40 million for any fiscal year, the bill would require the surcharge to be suspended for the following fiscal year. The bill would further exclude these surcharges from inclusion in the plans' and insurers' administrative expenses when determining whether it has expended "an excessive amount of the aggregate dues, fees and other periodic payments" according to statutory requirement. The bill would require plans and insurers to report annually, beginning May 15, 2010, to MRMIB and the Department of Managed Health Care (DMHC) the number of lives covered by their respective contracts and policies as of March 31 of each year. The bill would allow MRMIB, by regulations and pending sufficient funding, to develop tobacco use and morbid obesity risk categories that would remain in effect until January 1, 2015. It would also require MRMIB to release all program actuarial data for 2004 to 2007 to the Legislative Analyst's Office. The bill would apply the same premium formula for HIPAA PPOs as HMOs: 170% of standard rates. It would further prohibit plans or insurers from changing the premiums more than once every 12 months.

SCA 1 (Walters) Vote Requirements For Budget Bills
Version: Introduced 12/01/2008
Sponsor: Author
Status: 12/01/2008-First Reading

This bill would exempt budget bills from the referendum process. It would also exempt from the 2/3 legislative vote requirement any General Fund appropriation in a fiscal year that, when combined with all General Fund appropriations passed for that same fiscal year, total less than 5% of the General Fund appropriations made as of that same date during the immediately preceding fiscal year.